



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KSF ORTHOPAEDIC CENTER PA
17270 REDOAK DRIVE SUITE 200
HOUSTON TEXAS 77090

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

GUIDEONE MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-12-2117-01

MFDR Date Received

February 21, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Nicole Collier, PTA and Andrew Gromek, PTA are licensed but both are not eligible for a Medicare provider number or an NPI (National Provider Identification) number. Without these provider numbers we must bill under our licensed [sic] therapist's Angela Dailey, LPT since they both have NPI numbers which are required to be in box 24J of the 1500 HCFA when billing for workman compensation and Medicare charges."

Amount in Dispute: \$1,461.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Therefore per this rule the name and license number of the rendering provider (PTA) is required unless they are an unlicensed HCP then and only then would the bill be submitted under the name and license number of the supervising provider. Furthermore, per this rule, NPI is only required when the provider is ELIGIBLE. IF the rendering HCP were truly not eligible for an NPI then this field could be left blank. The lack of an NPI number does not dismiss the requirement to bill with the name and license of the rendering HCP."

Response Submitted by: Corvel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 8, 2011, September 19, 2011, September 23, 2011, September 26, 2011, October 3, 2011, October 5, 2011 and October 11, 2011	97110, 97140 and 97150	\$1,461.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits dated September 28, 2011, October 7, 2011, October 14, 2011 and October 26, 2011
 - B20 – Srvc partially/fully furnished by another providerExplanation of benefits dated October 14, 2011, October 24, 2011 and October 28, 2011
 - 150 – Payment adjusted/unsupported service level
 - R95 – Procedure billing restricted/See CMS policies
 - B20 – Srvc partially/fully furnished by another provider

Issues

1. Did the requestor submit the medical bills in accordance with 28 Texas Administrative Code §133.20?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §401.011, titled, *General Definitions*, states in pertinent part. "In this subtitle... (21) "Health care practitioner" means: (A) an individual who is licensed to provide or render and provides or renders health care; or (B) a nonlicensed individual who provides or renders health care under the direction or supervision of a doctor.
2. 28 Texas Administrative Code §133.20, titled, *Medical Bill Submission by Healthcare Provider*, states in pertinent part, (e)(2) states in pertinent part "(e) A medical bill must be submitted: 2) in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care..."
 - Review of the CMS-1500's for dates of service, September 19, 2011, September 23, 2011, September 26, 2011, October 3, 2011, October 5, 2011 and October 11, 2011 documents in box 31, that Tamara Ulrich, LPT billed for the disputed services.
 - Review of the "Physical Therapy: Daily Prog Note" documents that for dates of service, September 19, 2011, September 23, 2011, September 26, 2011, October 3, 2011, October 5, 2011 and October 11, 2011, Andy Gromek, PTA rendered the physical therapy services.
 - Review of the CMS -1500 for date of service September 8, 2011 documents in box 31 that Angela Dailey, LPT billed for the disputed services.
 - Review of the "Physical Therapy: Daily Prog Note" documents that for date of service, September 8, 2011, Nicole Collier, PTA rendered the physical therapy services.
 - The requestor did not meet the billing requirements of 28 Texas Administrative Code §133.20. As a result reimbursement cannot be recommended
3. For the reason stated above, the requestor is not entitled to reimbursement of the disputed charges rendered on September 8, 2011, September 19, 2011, September 23, 2011, September 26, 2011, October 3, 2011, October 5, 2011 and October 11, 2011.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	May 24, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.